



**Texas Department of Insurance**  
**Division of Workers' Compensation**  
Medical Fee Dispute Resolution, MS-48  
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

Requestor Name and Address:	MFDR Tracking #: M4-06-6047-01
EDINBURG REGIONAL MEDICAL CENTER 3255 W PIONEER PKWY ARLINGTON TX 76013	DWC Claim #:
	Injured Employee:
Respondent Name and Box #:	Date of Injury:
Texas Mutual Insurance Co. Box #: 54	Employer Name:
	Insurance Carrier #:

### PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

**Requestor's Position Summary:** "The operating cost-to-charge ratio for the hospital during this date of service was 20%. This claim was reimbursed at only 7% of total charges. We are asking for additional payment to be allowed to cover the cost of treating the patient on this date of service"

**Principal Documentation:**

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Medical Records
5. Total Amount Sought - \$2,181.79

### PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

**Respondent's Position Summary:** "Authorization was given for an outpatient ORIF of tibial plateau fracture of left knee (Exhibit 3). Had the HCP rendered this service in-patient the reimbursement would have been \$1,118.00 based on a one day surgical per diem. Texas Mutual allowed \$1,223.65 for the out-patient hospital stay. Texas Mutual believes that amount to be more than fair and reasonable reimbursement consistent with the Texas Labor Code for the service rendered."

**Principal Documentation:**

1. Response Package

### PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
8/31/2005-9/6/2005	W10, 45, 894, 793, 150, 426, 713	Outpatient Surgery	\$2,181.79	\$0.00
Total Due:				\$0.00

### PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on May 19, 2006. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on June 5, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
  - W10 – NO MAXIMUM ALLOWABLE DEFINED BY FEE GUIDELINE. REIMBURSEMENT MADE BASED ON

INSURANCE CARRIER FAIR AND REASONABLE REIMBURSEMENT METHODOLOGY.

- 150 – PAYMENT ADJUSTED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE.
  - 45 – CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
  - 426 – REIMBURSED TO FAIR AND REASONABLE.
  - 713 – FAIR AND REASONABLE REIMBURSEMENT FOR THE ENTIRE BILL IS MADE ON THE 'O/R SERVICE' LINE ITEM.
  - 793 – REDUCTION DUE TO PPO CONTRACT.
  - 894 – FAIR AND REASONABLE REIMBURSEMENT FOR THE ENTIRE BILL IS MADE ON THE "O/R SERVICE" LINE ITEM.
2. The insurance carrier denied or reduced disputed services with reason code 793, "REDUCTION DUE TO PPO CONTRACT." Review of the submitted documentation finds no documentation to support a PPO contract or a contractual agreement between the parties to this dispute. The Division concludes that denial reason code 793 is not supported. Therefore, these services will be reviewed per applicable Division rules and statutes.
  3. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
  4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
  5. Division rule at 28 TAC §133.307(e)(2)(B), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include "a copy of each explanation of benefits (EOB)... relevant to the fee dispute or, if no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB." Review of the documentation submitted by the requestor finds that the request does not include the EOB detailing the carrier response to the request for reconsideration. Neither has the requestor submitted convincing evidence of carrier receipt of the provider request for an EOB. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(e)(1)(B).
  6. Division rule at 28 TAC §133.307(g)(3)(A), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including "documentation of the request for and response to reconsideration (when a provider is requesting dispute resolution on a carrier reduction or denial of a medical bill) or, if the carrier failed to respond to the request for reconsideration, convincing evidence of the carrier's receipt of that request." Review of the submitted evidence finds that the requestor has not provided documentation of the insurance carrier's response to the request for reconsideration or convincing evidence of the carrier's receipt of that request. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(A).
  7. Division rule at 28 TAC §133.307(g)(3)(C)(iii), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the Texas Labor Code and commission [now the Division] rules, and fee guidelines, impact the disputed fee issues." Review of the submitted documentation finds that the requestor did not state how the Texas Labor Code and Division rules impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iii).
  8. Division rule at 28 TAC §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iv).
  9. Division rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
    - The requestor's rationale for increased reimbursement from the *Table of Disputed Services* states that "The operating cost-to-charge ratio for the hospital during this date of service was 20% This claim was reimbursed at only

7% of total charges. We are asking for additional payment to be allowed to cover the cost of treating the patient on this date of service.”

- The requestor did not submit documentation to support the cost-to-charge ratio for the hospital during the disputed dates of service.
- The Division has previously found that a reimbursement methodology based on hospital costs does not produce a fair and reasonable reimbursement amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

“The Commission [now the Division] chose not to adopt a cost-based reimbursement methodology. The cost calculation on which cost-based models... are derived typically use hospital charges as a basis. Each hospital determines its own charges. In addition, a hospital's charges cannot be verified as a valid indicator of its costs... Therefore, under a so-called cost-based system a hospital can independently affect its reimbursement without its costs being verified. The cost-based methodology is therefore questionable and difficult to utilize considering the statutory objective of achieving effective medical cost control and the standard not to pay more than for similar treatment to an injured individual of an equivalent standard of living contained in Texas Labor Code §413.011. There is little incentive in this type of cost-based methodology for hospitals to contain medical costs.”

- The requestor did not discuss or explain how payment of the amount sought would result in a fair and reasonable reimbursement.
- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
- The requestor did not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

10. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code sections §133.307(e)(2)(B), §133.307(g)(3)(A), §133.307(g)(3)(C), and §133.307(g)(3)(D). The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

#### **PART VI: GENERAL PAYMENT POLICIES/REFERENCES**

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311  
28 Texas Administrative Code §133.307, §134.1  
Texas Government Code, Chapter 2001, Subchapter G

#### **PART VII: DIVISION DECISION**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

#### **DECISION:**

\_\_\_\_\_  
Authorized Signature

**Grayson Richardson**  
\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

**5/28/2010**  
\_\_\_\_\_  
Date

## PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**